Exhibit 3

***United States of America ex rel. Ven-A-Care of the Florida Keys, Inc., et al. v. Dey, Inc., et al.*, Civil Action No. 05-11084-PBS**

Exhibit to the August 28, 2009 Declaration of Sarah L. Reid In Support of Defendants' Common Opposition to Plaintiffs' Motion for Partial Summary Judgment

UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF MASSACHUSETTS

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IN RE: PHARMACEUTICAL	)	MDL NO. 1456
INDUSTRY AVERAGE WHOLESALE	)	CIVIL ACTION
PRICE LITIGATION	)	01-CV-12257-PBS
THIS DOCUMENT RELATES TO	)	
U.S. ex rel. Ven-a-Care of	)	Judge Patti B. Saris
the Florida Keys, Inc.	)	
v.	)	Chief Magistrate
Abbott Laboratories, Inc.,	)	Judge Marianne B.
No. 06-CV-11337-PBS	)	Bowler

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Videotaped 30(b)(6) deposition of

THE STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE BY JOSEPH L. FINE

Baltimore, Maryland

Tuesday, December 9, 2008

9:00 a.m.

payment rates for pharmaceuticals?

A. Any regulatory change.

Q. It's supposed to go through the legislature?

A. Through this committee, yes. And this committee is a standing committee throughout the year. It's not just in session.

Q. So the executive branch isn't making changes in payment rates willy nilly without some review of the legislature?

A. Right. But there is a provision for emergency. And you have to go through ALR for emergency also. And that's a fast track.

Q. If you would go to the third paragraph on page 142. This is talking about the fact that amendments will set EAC at WAC plus 10 percent. Do you see that?

A. Mm-hmm.

Q. The last sentence says there "Extemporaneously compounded prescriptions and over-the-counter products will not be subject to this pricing methodology but will continue to be priced

under the current methodology."

A. Mm-hmm.

Q. What does that mean?

A. Okay. In pharmacy in the old days you compounded a prescription. Not everything was in a tablet or a capsule. So extemporaneously compounded prescriptions is that at the pharmacy counter you mix a cream with an ointment with some powdered drug and you do when you do and you put it in a tube or -- you compound a prescription. Okay. The ingredients that are used in that will not be based on the wholesale acquisition cost. It's the total price of the compound using all the AWPs for that.

So the bottom line, if you had three ingredients in it it would be one price charged for the three ingredients. And the NDC number, which depicts the products that were used, in those days we had a blanket number which we used, 00998 with all zeros, which depicted compounded prescription. Okay? Those products were -- the dose prescriptions were priced if they were under -- they were priced if they were over $15, meaning they had to be sent in so we

could review what they're charging. Because you could certainly -- something that you were normally charging $20 for and the pharmacy charged $80 we would pay 80 if we didn't review it. And 20 is over the 18. So we took anything that was under 18 and we let it go through the 998, but anything above it, if that sounds -- if you understand that point.

And the other, what was the issue about -- the over-the-counter products were payable one time. It's 50 percent greater than the AWP. So therefore we would pay -- if it was Maalox and it was $1 a bottle we would pay up to 1.50 for the Maalox. There was no dispensing fee involved for over-the-counter products. That kind of thing. Let me just say it another way.

As long as the AWP -- the way pharmacy charged for drugs over the counter, it was a wholesale price AWP, a normal markup was 150 percent. So it's one and a half times, so a dollar would be a dollar fifty. When the cost of the over the counter drug became greater than the normal dispensing fee, then the normal dispensing fee went into play. For instance, if the dispensing fee was $4 and it was a

$12 AWP we wouldn't just pay $18, we would pay no more than 12 and 4, which was $16.

Q. Got it.

A. Okay.

Q. So for the over-the-counter products the markup on the ingredient cost would be covering the dispensing fee?

A. Yes.

Q. Up to a limit of --

A. No greater than the dispensing fee.

Q. Got it. Now, let me give you just a hypothetical question. Let's say at the time this memo was written and this policy goes into effect there's a home infusion pharmacy that was administering vancomycin to a patient. And in order to do that he has to compound it with a dilutant like sodium chloride. Is that the type of claim that would fall within this carve-out of the methodology?

MS. YAVELBERG: Objection, form.

A. We're talking here '91. To be frank with you, there was very little home infusion done in '91. Very little. The way it really happened was that the

patient because of the lack of sophistication for home infusion was hospitalized for -- vanco is a serious drug. And you don't normally give vanco at home. And we're talking about the outpatient pharmacy services. And I don't recall it being an issue in '91.

But to answer your question if it were so, if an outpatient pharmacy were dispensing the product it would fall under the same guidelines as any other compounded prescription.

Q. Why did the regulations at this time at least carve out compounded prescriptions from the new methodology?

A. Because the idea of compounding was its own issue. It costs more to compound. It takes more time for pharmacists to compound. It was not something that we were interested in limiting the cost -- not the cost, but addressing the cost on.

Q. So would it be fair to say, Mr. Fine -- to make sure I understand your testimony correctly here, and tell me if I'm not getting it right -- that because of the additional cost to compound prescriptions at this time you didn't want to reduce

the ingredient cost reimbursement?

MS. YAVELBERG: Objection, form.

A. I hear what you're saying. But -- I'm trying to think back 16, 17 years. We had to hand price these products. And it was difficult. And that played a part into it. Not only what it cost the pharmacist to put this together. So it's very hard for me to say exactly why the reason was.

Q. And if you look at the next page it states "These amendments will also increase the provider's dispensing fee from a flat rate of $3.70 to $4.69 for prescriptions with an allowable cost below $34.92 and to $5.92 where the allowable cost is at or above $34.92." Is that right?

A. Mm-hmm.

Q. So at the same time that Maryland decreased the payment for ingredient cost it increased the dispensing fee, right?

MS. YAVELBERG: Objection, form.

A. This is what happened at the time, yes.

Q. I'd like to hand you what we've marked previously as Abbott Exhibit 581. Mr. Fine, these

of that product and that's why it was given at that price. And then in a nursing home it's a little different. The nursing home has control of the patients within the facility. And the medical director works hand in glove with the nursing home pharmacy and what happens is that they select a preferred product that the pharmacy can get at the best price and literally the pharmacy negotiates, bids against one company for the same product against the other, to obtain the preferred drug for that facility.

Q. And could retail pharmacies do the same thing?

A. No.

MR. TORBORG: Object to form.

A. No. Retail pharmacies could not do the same because retail pharmacies are open to the public. It's not a closed system. So whatever prescription comes in is what prescription is written for for whatever product and the retail pharmacy must carry all products.

Q. Let me jump to compounded drugs for a couple of minutes.

A. Okay.

Q. Do you remember talking about that earlier today?

A. Yes.

Q. Now, why were compounded drugs priced manually?

A. Because they had multiple ingredients. A pharmacy billing was a single entity, line entity, for the compound. And there's no way to ascertain what products -- what ingredients were in the compound without pricing them manually. We had a $15, I believe, break point where we trusted the pharmacy that if there was a compound under $15 -- a charge under $15 -- that that was allowed to go through the system. But over $15 each one had to be manually priced.

Q. And when you say manually priced can you explain how Maryland did that?

A. The pharmacist reviewing the price would look at the ingredients that were used and then ascertain the quantity that was used in the compound, then go through the formulary file, the First Databank

file, which had the pricing and would then calculate the price individually for each ingredient, total it, add the dispensing fee, and allow that for the payment.

Q. Now, compound drugs I think you testified earlier a lot of these were the -- you called them injectables or infusion drugs; is that right?

A. Infusion drugs.

Q. Are there also supplies that also sometimes go along with these drugs?

A. It can't be administered without the tubing and/or pump and/or stand depending on the kind of product.

Q. And did Maryland reimburse for those supplies?

A. Certainly.

MR. TORBORG: Object to form.

A. Yes.

MS. YAVELBERG: What's the objection?

MR. TORBORG: I think the term supply is a little vague.

BY MS. YAVELBERG: